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EDITORIAL

The future role of general practice: managing multiple agendas

How to ensure sustainable care in a complex world of evidence, context, organization and personal care?

With this question the Nordic Congress of General Practice in 2009 did not ask *whether* 'sustainable care' should be ensured, but *how* [1]. Sustainable medical and social care, as we are familiar with it in the Nordic welfare state model, apparently is found to be threatened in 'a complex world of evidence, context, organization and personal care' [2].

The industrialization of general practice

During the most recent decades general practice has changed considerably. The growth of management, production-line ways of working, and standardization of techniques, all incorporated as accessible in a scientific context, have obvious similarities to the process that converted engineering as a profession from a craft discipline to an industrial one. The process of change in general practice can thus be seen as a transformation from a loosely organized enterprise with wide scope for individual interpretation into a predictable and prescribed series of tasks in the management of public health [3]. The individuality of the patient is not ignored but it is subordinated to the systematic application of scientific knowledge. The idiosyncrasies of the person with diabetes are not allowed to override the need for treatment regimens to be optimized, and for the risk of serious disabling, potentially life-threatening, and costly complications to be reduced. Industrialization processes may thus change person-centred family medicine into system-centred primary care [3].

The industrialization of general practice has come to stay. The transformation of general practice into primary care probably carries huge advantages. The standards of medical care will probably rise and the variations in clinical activity will decrease as 'best practice' becomes a core component of contracts. Evidence-based medicine allows fewer doctors to hide behind idiosyncratic treatments or simple ignorance [3].

But if it is maximized without our conscious intervention we might see the growth of a professionally diversified workforce and part-time working, which is target-driven with limited responsiveness to individuals. If we are not careful, 'the patient-as-client' will receive 'service-with-a-smile' from a 'customer-aware' 'self- protecting doctor' delivering 'strictly on contract' [4]. In a worst-case scenario the benefit from the industrialization of general practice may fade against a backdrop of professional discontent and disengagement, with subsequent dissatisfied patients and political conflict. In a best-case scenario piecemeal and partial adaptations of the process could be enriched by goal- and community-oriented approaches, where old and new knowledge can be integrated into the personal relationships at the centre of family medicine [3].

Will commitment to 'whole-person medicine' be lost?

Should we fear that this industrial revolution of our work will degrade the quality, and that ill people will receive poorer services because of all the managerial efforts to reorganize and standardize clinical practice with indicators and 'smileys', increasing productivity for the same costs?

We anticipate that personal care is demanded since the ethos of general practice emphasizes the importance of long-term personal relationships fostering trust and allowing open communication.

But will patients of tomorrow shop for medical services at the expense of building relationships and continuity? [5]

Advances in technology have made medical information available to everybody. Patients sometime challenge us with the newest information but, without the filtering and understanding of reality or in which setting things are going on, they may get all the facts wrong. Our patients still trust and appreciate us [6] but the traditional relationship may be called into question. Increasingly, complaints and second-opinion seeking are reported, even though the majority of cases can most often be explained as lack of communication and clarification of expectations [7]. So in this light, then, how can we ensure

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sustainable care looked at through GPs' eyes? What shall we prioritise and which is the way to go?

Education and translating knowledge into practice

Having no evidence-based information on what will be most likely to lead to sustainable care in our setting, it is tempting to state that sustainability must be based on qualified professional upbringing and reflection. This implies education with lifelong training combined with strategies to translate current knowledge into practice, built into the core values of family medicine [8,9].

Experience-based medicine – scientific and clinical knowledge

We claim that our discipline is founded on scientific knowledge. Yet, although the ideas of evidence-based medicine are widely accepted, clinical decisions and methods of care are based on much more than just the results of controlled experiments [10]. Clinical knowledge consists of interpretive action and interaction, factors that involve communication, opinions, attitudes, and experiences. Where traditional quantitative research reports phenomena that can be controlled, measured, and counted, qualitative research can help us understand and uncover the tacit knowledge of experienced practitioners. 'Experience-based medicine' [11] may reveal that the 'correct' thing to do is not always the right thing to do. Qualitative inquiry increasingly contributes to a broader understanding of what we actually do, although we are just at the start of sharing this knowledge and methods from other disciplines, such as sociology, psychology, and other humanistic disciplines [12].

Continuing professional development (CPD)

Patient perceptions of incompetence will erode confidence and create a barrier to developing a therapeutic relationship. Medical expertise is therefore the prerequisite for professionalism, which of course is the cornerstone in under- and postgraduate education. However, family medicine prioritizes combining technical skills with an understanding manner. Communication skills are accessible for significant improvements in training. GPs possess experience in interpersonal aspects allowing us to deconstruct concepts such as empathy, compassion, and integrity and show our young trainee doctors how we do things.

Family medicine professionalism is therefore more than a nine-to-five job [3,14]. We must be specific and define this more and integrate it into the clinical upbringing [15]. If we can also provide valid feedback regarding competence in this aspect, it may serve to counteract the relative marginalization of these values in the curricula of today's physicians, who are increasingly exposed to technological revolutions. If, in the face of a shortage of GPs, we prioritise hands for heads and hearts, we may end up losing our distinctive feature of trustworthiness.

If, however, we engage in lifelong professional learning activities and share and develop 'experience-based clinical practice', we may enhance the chances of acquiring competences that will fulfil our own needs and expectations, as well as meeting the health and social needs of the populations being served. Small-group-based training seems to provide the greatest impact [16].

Team and interdisciplinary relations

The ageing demography highlights the need to prevent disability and to find effective ways to care for older people's chronic diseases and variety of complex health problems. GPs have a central role in treating and coordinating primary care services to older people. Educating municipality employees and GPs in their local setting has shown to be associated with improved functional outcomes in people receiving their services [17]. Introducing simple assessment tools and how interdisciplinary follow-up could be facilitated showed clear synergistic effects when training was offered to both GPs *and* their homecare system employees. Information provision alone does not change clinician behaviour [18]. Implementation and maintenance of new interdisciplinary initiatives must literally respect local professional traditions and culture to have a chance of translating knowledge into practice [19].

Community care

GP commitment and engagement in the public health service may have a decisive influence on the directions of social development. GPs at the heart of local health service planning may influence managerial decisions with an effect on patient care, and act as advocates for quality. To drive forward policies that would benefit patient care will be a wise long-term strategy rather than sticking to the defence of conservative economic organizational traditions that limiting the rate of change [3].

Market and equity

Family medicine is faced with market liberalism throughout the world, giving rise to new perspectives

on economic prosperity, but also widening gaps between the rich and a growing number of unemployed, low-educated poor and marginalized people. Poverty and long-term unemployment are becoming permanent problems, and the recession we are experiencing currently will also affect people in the Nordic countries. The challenge to family medicine is therefore to develop an understanding of the associations between social risk factors on a population level and their clinical expression in individuals in terms of illness, sick-role behaviour (if they have a job), manifestation of disease, and potential for constructive coping. Family medicine can contribute to a universally available primary healthcare, meeting the needs also of those who are not in the best position to pay [20].

The future

Meeting people at the primary care level provides unique opportunities to be sensitive and responsive to unexpected changes in society. In a world plagued by unforeseen discontinuities, general practice will need to maintain its core of 'personal doctoring' [20]. Be available, have and take the time to talk, really listen to what is said, explain things, inform at a reasonable pace, and coordinate not only for secondary care but also for care in the community. In the current complex world context, our priorities and actions should be 'justifiable and responsible', not only evidence-based as is the case here and now, but also in a wider, more distant, and even global perspective [21,22]. General practice may in this way provide a vital contribution to ensure sustainable care.

Audentes fortuna iuvat – Fortune favours the brave
Let us be brave – and hope for the fortune!

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